

2024 Summary of Benefits

**Medicare Advantage Plans with Part D
Prescription Drug Coverage**

Sonder Heart Healthy (HMO C-SNP)

January 1, 2024 – December 31, 2024

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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, www.sonderhealthplans.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Sonder Heart Healthy (HMO C-SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Sonder Heart Healthy (HMO C-SNP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this Booklet

- Things to Know About **Sonder Heart Healthy (HMO C-SNP)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-888-428-4440 (TTY: 711).

Things to Know About Sonder Heart Healthy (HMO C-SNP)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-428-4440, TTY: 711.

- If you are not a member of this plan, call us at 1-888-428-4440, TTY: 711.
- Our website: www.sonderhealthplans.com.

Who can join?

To join **Sonder Heart Healthy (HMO C-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area and have been diagnosed with Chronic Heart Failure or Cardiovascular Disorder (limited to: cardiac arrhythmias, coronary artery disease, peripheral vascular disorder and chronic venous thromboembolic disorders). Our service area includes these counties in Georgia: Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Paulding and Rockdale.

Which doctors, hospitals, and pharmacies can I use?

Sonder Heart Healthy (HMO C-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (<http://www.sonderhealthplans.com>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <http://www.sonderhealthplans.com>.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Sonder Health Plans, Inc.

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SECTION II - SUMMARY OF BENEFITS

Sonder Heart Healthy (HMO C-SNP)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

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| Monthly Plan Premium | You do not pay a separate monthly plan premium for Sonder Heart Healthy (HMO C-SNP). You must continue to pay your Medicare Part B premium. |
| Deductible | Medical Deductible: \$0 Deductible. Prescription Drug Deductible: \$0 Deductible. |
| Maximum Out-of-Pocket Responsibility | Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$3,850 for services you receive from in-network providers. <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p> |

COVERED MEDICAL AND HOSPITAL BENEFITS

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| Inpatient Hospital | <p><u>In-Network:</u></p> <p>Days 1-5: \$350 Copay per day for each admission. Days 6-90: \$0 Copay per day.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.</p> |
| Outpatient Hospital | <p><u>In-Network:</u></p> <p>Outpatient hospital: \$280 Copay. Outpatient Surgery: \$280 Copay. May require prior authorization. May require a referral from your doctor.</p> |
| Ambulatory Surgical Center | <p><u>In-Network:</u></p> <p>Ambulatory Surgical Center: \$180 Copay. May require prior authorization. May require a referral from your doctor.</p> |

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| Doctor's Office Visits | <p><u>In-Network:</u></p> <p>Primary care physician visit: \$0 Copay</p> <p>Specialist visit: \$0 Copay</p> |
| Preventive Care (e.g., flu vaccine, diabetic screenings) | <p><u>In-Network:</u></p> <p>\$0 Copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> |
| Emergency Care | <p><u>In-Network:</u></p> <p>\$120 Copay per visit.</p> <p>Worldwide Emergency Coverage: \$0 copay, \$10,000 maximum allowable for all worldwide urgent/emergency services.</p> |
| Urgently Needed Services | <p><u>In-Network:</u></p> <p>\$25 Copay per visit.</p> <p>Worldwide Urgent Coverage: \$0 copay, \$10,000 maximum allowable for all worldwide urgent/emergency services.</p> |
| Diagnostic Services / Labs/ Imaging | <p><u>In-Network:</u></p> <p>Diagnostic tests and procedures: \$0 Copay</p> <p>Lab services: \$0 Copay</p> <p>Diagnostic Radiology Services (such as MRI, CAT Scan): \$275 Copay</p> <p>X-rays: \$0 Copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.</p> <p>May require a referral from your doctor.</p> |
| Hearing Services | <p><u>In-Network:</u></p> <p>Exam to diagnose and treat hearing and balance issues: \$30 Copay.</p> <p>Routine hearing exam (up to 1 visit(s) every year): \$0 Copay.</p> <p>Hearing aids: You have the option to purchase hearing aids from two categories:</p> <ul style="list-style-type: none"> • TruHearing Advanced - \$699 Copay per ear, per year (1 hearing aid) • TruHearing Premium - \$999 Copay per ear, per year (1 hearing aid) |

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| <p>Dental – Comprehensive and Preventive Services</p> | <p><u>In-Network:</u></p> <p>You receive \$2,000 per year allowance towards the purchase of comprehensive and preventive dental services, including:</p> <ul style="list-style-type: none"> • Exams • Prophylaxis • Fluoride • X-rays • Non-routine services • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics <p>Preventive dental services:</p> <ul style="list-style-type: none"> • Oral exam (up to 1 visit(s) every six months): \$0 Copay. • Cleaning (up to 1 visit(s) every six months): \$0 Copay. • Fluoride treatment (up to 1 visit(s) every six months): \$0 Copay. • Dental X-rays (up to 1 visit(s) every two years): \$0 Copay. |
| <p>Vision Services</p> | <p><u>In-Network:</u></p> <p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$30 Copay.</p> <p>Routine eye exam (up to 1 visit(s) every year): \$0 Copay.</p> <p>Eyeglasses or contact lenses after cataract surgery:</p> <p>Contact lenses: \$0 Copay.</p> <p>Eyeglasses (frames and lenses): \$0 Copay.</p> <p>Our plan pays up to \$200 every year for eyewear.</p> |

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| Mental Health Care | <p><u>In-Network:</u></p> <p>Outpatient group therapy visit: \$40 Copay.</p> <p>Individual therapy visit: \$40 Copay.</p> <p>Inpatient Mental Health Care:</p> <p>Days 1-5: \$350 Copay per day for each admission.</p> <p>Days 6-90: \$0 Copay per day.</p> |
| Skilled Nursing Facility (SNF) | <p><u>In-Network:</u></p> <p>Days 1-20: \$0 Copay per day.</p> <p>Days 21-100: \$184 Copay per day.</p> |
| Outpatient Rehabilitation | <p><u>In-Network:</u></p> <p>Occupational therapy visit: \$40 Copay.</p> <p>Physical therapy and speech and language therapy visit: \$40 Copay.</p> <p>May require prior authorization.</p> <p>May require a referral from your doctor.</p> |
| Ambulance | <p><u>In-Network:</u></p> <p>Ground Ambulance: \$225 Copay.</p> <p>Air Ambulance: \$450 Copay.</p> |
| Transportation | <p><u>In-Network:</u></p> <p>You receive up to 12 one-way trips per year for non-emergency transportation to plan approved health related locations.</p> |
| Medicare Part B Drugs | <p><u>In-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 20% Coinsurance.</p> <p>Other Part B drugs: \$35 copay for Insulin.</p> <p>May require prior authorization.</p> |
| PRESCRIPTION DRUG BENEFITS | |
| Deductible | Prescription Drug Deductible: \$0 Deductible. |
| Initial Coverage | You pay the following until your total yearly drug costs reach \$5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan. |

| Standard Retail Cost-Sharing | | | |
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| Tier | One-month supply | Two-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | \$0 Copay | Not Applicable | \$0 Copay |
| Tier 2 (Generic) | \$15 copay | Not Applicable | \$45 copay |
| Tier 3 (Preferred Brand) | \$47 copay \$35 copay for Insulin | Not Applicable | \$141 copay \$70 copay for Insulin |
| Tier 4 (Non-Preferred Drug) | \$100 copay | Not Applicable | \$300 copay |
| Tier 5 (Specialty Tier) | 33% coinsurance | Not Applicable | 33% coinsurance |
| Tier 6 (Specialty Tier) | \$0 Copay | Not Applicable | \$0 Copay |
| Preferred Retail Cost-Sharing | | | |
| Tier | One-month supply | Two-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | Not Applicable | Not Applicable | Not Applicable |
| Tier 2 (Generic) | Not Applicable | Not Applicable | Not Applicable |
| Tier 3 (Preferred Brand) | Not Applicable | Not Applicable | Not Applicable |
| Tier 4 (Non-Preferred Drug) | Not Applicable | Not Applicable | Not Applicable |
| Tier 5 (Specialty Tier) | Not Applicable | Not Applicable | Not Applicable |
| Tier 6 (Specialty Tier) | Not Applicable | Not Applicable | Not Applicable |

| Standard Mail Order | | | |
|-------------------------------|-------------------------|-------------------------|---------------------------------------|
| Tier | One-month supply | Two-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | Not Applicable | Not Applicable | \$0 Copay |
| Tier 2 (Generic) | Not Applicable | Not Applicable | \$0 Copay |
| Tier 3 (Preferred Brand) | Not Applicable | Not Applicable | \$141 copay \$70 copay for Insulin |
| Tier 4 (Non-Preferred Drug) | Not Applicable | Not Applicable | \$300 copay |
| Tier 5 (Specialty Tier) | Not Applicable | Not Applicable | 33% coinsurance |
| Tier 6 (Specialty Tier) | Not Applicable | Not Applicable | \$0 Copay |

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan's "**Evidence of Coverage**" on our website (www.sonderhealthplans.com) for complete information about your costs for covered drugs.

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| Coverage Gap | <p>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$5,030.</p> <p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$8,000, which is the end of the coverage gap.</p> <p>Our plan covers Tier 1 Preferred Generics in the coverage gap.</p> |
| Catastrophic Amount | After your yearly out-of-pocket drug costs reach \$8,000, you pay nothing. |

| Additional Benefits Available to You | |
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| Fitness Benefit | \$0 Copay |

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| | <p>You receive access to the Silver&Fit Healthy Aging and Exercise program. As part of this program, you have the following options available to you:</p> <ul style="list-style-type: none"> • Fitness center membership at a participating fitness center near you • Home kit, if you are unable to visit a fitness center or prefer to exercise at home • Daily virtual workout classes streamed live on popular social media outlets • Digital workout classes available on mobile app or website | | | | | |
| <p>Over The Counter Items</p> | <p>You receive \$125 per quarter allowance towards the purchase of OTC items from the approved list.</p> | | | | | |
| <p>SSBCI Benefits for members who have qualifying Chronic medical conditions</p> | <p>Eligible Chronic Conditions Include: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; and Stroke.</p> <p>You receive an allowance of \$235 per month to apply towards the list of services below</p> <table border="1" data-bbox="391 825 1515 1194"> <tr><td>Gasoline</td></tr> <tr><td>Home Safety Access / Modifications</td></tr> <tr><td>Social /Active Club Membership</td></tr> <tr><td>Internet / Cell Data</td></tr> <tr><td>Sports License (Hunting / Fishing)</td></tr> </table> <p>Grocery Card</p> <p>You receive a \$75 per month allowance for the purchase of groceries</p> <p>Routine Meal Delivery</p> <p>You receive up to 10 meals delivered to their home per month. No qualifying event is required</p> <p>Non-Emergent, Non-Medical Transportation</p> <p>You receive up to 50 one-way trips for non-emergent transportation. Trips do not need to be medical in nature.</p> | Gasoline | Home Safety Access / Modifications | Social /Active Club Membership | Internet / Cell Data | Sports License (Hunting / Fishing) |
| Gasoline | | | | | | |
| Home Safety Access / Modifications | | | | | | |
| Social /Active Club Membership | | | | | | |
| Internet / Cell Data | | | | | | |
| Sports License (Hunting / Fishing) | | | | | | |
| <p>Personal Emergency Response System</p> | <p>You receive one personal emergency response system which includes a base unit and optional wearable device.</p> | | | | | |

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| In-Home Support Services | You receive in-home support services for \$0 copay. Services are provided in 4 hour per day increments up to 104 hours per year. Services available include: |
| | Respite Care |
| | Caregiver Training |
| | In-Home Safety Assessment |
| | Medication Reconciliation |
| | Support for activities of daily living including things such as bathing, dressing, grooming, meal preparation and light housekeeping |
| Routine Foot Care | You pay \$0 for up to 6 visits per year. |
| Routine Chiropractic Services | You pay \$0 for up to 12 visits per year. |
| Flexible Spending Card | You receive a \$500 per year allowance towards the purchase of additional Dental, Vision or Hearing services |

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-888-428-4440 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-428-4440 (TTY: 711).

Sonder Heart Healthy is an HMO plan with a Medicare contract. Enrollment in **Sonder Heart Healthy** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Sonder Health Plans, Inc. members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Sonder Health Plans, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-428-4440 (TTY 711).

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.sonderhealthplans.com or call 1-888-428-4440 (TTY 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.